

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034867
4646 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4646

FILED SEP 24 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Leawood	
Length of stay in 1b 1 Month		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 9706 Overbrook Road	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JESSICA B LOGAN		4. DATE OF DEATH Month Day Year September 9 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/2/1900
9. AGE (last birthday) 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10b. KIND OF BUSINESS OR INDUSTRY Missouri Plating Company	
11. BIRTHPLACE (City and state or country) Rochester, Kentucky		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME John T. Jackson		13b. MOTHER'S MAIDEN NAME Alice G. England	
14. NAME OF HUSBAND OR WIFE Roy W. Logan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. INFORMANT Roy W. Logan, 9706 Overbrook Road		17. ADDRESS Leawood, Kansas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia Colon with Metastases</u> DUE TO (b) <u>to Liver, Lung & Brain</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 1962</u> to <u>Sept 9 62</u> and last saw her alive on <u>Sept 8 62</u> Death occurred at <u>3:49 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>AW Robinson MD</u> (Degree or title)	
22b. ADDRESS <u>43 W. Journal</u>		22c. DATE SIGNED <u>9-10-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE Sept. 11, 1962	23c. NAME OF CEMETERY OR CREMATORY Mount Moriah	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo		25. DATE RECD. BY LOCAL REG. 9-11-62	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

W. Robinson MEDICAL CERTIFICATION

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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1130-5120
Dr. A. W. Robinson
4520 Wornall Road
JE 1 0552 - 208 Suite

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P.O. Address Indy, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.